Administrative Closure
Alleged Research Irregularities
VA Western New York Health Care System (528/00)
Buffalo, New York
MCI# 2012-01687-HI-0436

The VA Office of Inspector General (OIG) Office of Healthcare Inspections received an inquiry from Congresswoman Kathy Hochul regarding a research project entitled; *Cognitive Assessment of Veterans after Traumatic Brain Injury* (HSR&D SDR 06-162) that was being managed at the Western New York Health Care System VA Medical Center (facility), part of Veterans Integrated Service Network (VISN) 2. The OIG received allegations that the project's funding was mismanaged and funding expired before it should.

We conducted an onsite review on August 22–23, 2012. In addition to conducting interviews, we reviewed the following documents: (1) Report from the facility dated July 7, 2011[1]; (2) Merit Review Application for SDR-06-162 dated March 3, 2008; (3) VISN 2, Compliance and Business Integrity Report on Research & Development Regulatory Compliance, dated April 27, 2012; (4) VHA policies, directives and guidelines; (5) SDR-06-162 related documentation including Research Employee SF-50 records, invoices, receipts, fiscal documentation for this project's Fund Control Points.

We substantiated that funding for the project was mismanaged. From 2009–2011, the Research Service experienced unusually high turnover in both the positions of Chief of the Service and Research Administration Officers. During this period, there were three Associate Chiefs of Staff Research Service (ACOS Research) and four different Research Administration Officers, causing a breakdown in communication and processes. Additionally, the Principle Investigator on this project was new to the position and lacked the knowledge and skills necessary to manage this project.

The review conducted by the facility identified numerous expenses that did not follow the budget plan for the project. Purchases, including office furniture, break room equipment, and an ice machine, were made that were not on the budget plan. The Principle Investigator hired research staff much later than called for in the funding plan, which was the primary reason that $92,282 of expiring funds were pulled back by VA Central Office. These same employees were hired under a term contract for 3 years, which extended the term later than the funding, creating a budget shortfall of $106,000 in FY2011. The shortfall was paid for by the facility in order to complete the project. The review identified lapses in oversight and management and made recommendations to address those issues. We concur with those findings and the action plan that addressed those issues.

Additionally, some of the same business integrity issues were identified in the VISN 2 compliance audit report dated April 27, 2012. This report included findings about the lack of administrative knowledge within the research service staff, as well as identified communication problems between the ACOS Research, Research Administration Staff and Principle Investigators. We concur with the findings and recommendations made and actions taken.

Based on our review and the reviews by the facility and VISN 2, we recommend administrative closure.

Approved by: _____ 10/9/12
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

[1] *Research FCP Review – Health Services Research and Development Service (HSR&D) TBI Study FCP 4017, 4024 and 016*